NJU CANCER TREATMENT CENTERS
Excellence In Care

Dear Patient;

We have scheduled you for a follow up appointment with Dr. Glen Gejerman
at the NJU Cancer Treatment Center for a post radiation treatment evaluation.

For this appointment, please be sure to bring your driver's license (or any legal form of identification), your insurance cards and any co-pay/co-insurance that is due at the time of this appointment.

These documents are needed for your follow-up appointment. Please complete these forms and bring them with you on the day of your appointment.

Please do not hesitate to call us (201) 881-1000 option 4 then option 1 if you have any questions or need further information.

Respectfully yours,
NJU Cancer Treatment Centers

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# PATIENT MEDICATION LIST-UPDATE
## Follow-Up Appointment

Your Name: _____ Date of Birth: ____/____/_____ MR#: _____*(office use only)*

Form completed by:_____Relationship to Patient:_____Contact #: _____

| | NAME | PHONE |
|---|---|---|
| **PRIMARY DOCTOR** | | |
| **PHARMACY** | | |
| Please check one box: ☐ Pills ☐ Liquid medication only | | |

| ALLERGIES: Medication, Food, Environmental | ALLERGIC REACTION: (hives, redness, itching) |
|---|---|
| | |
| | |

MEDICATIONS: (IF YOU NEED MORE SPACE REGARDING ALLERGIES & MEDICATIONS, PLEASE CONTINUE ON THE BACK OF THIS FORM)

☐ I am current not taking any medications at home.

**Have you received the FLU SHOT?☐ No ☐ Yes** (provide date of most recent) _____

| NAME OF **HOME** MEDICATION (include prescriptions, over-the-counter meds, herbal supplements, patches, inhalers, eye drops, vitamins) | DOSE (mg, units, puffs, drops) | ROUTE (by mouth, patch) | FREQUENCY (how often do you take it) | DATE & TIME OF LAST DOSE |
|---|---|---|---|---|
| | | | | |
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| | | | | |
| | | | | |
| | | | | |
| Patient/Other Signature | | | Date/Time | |
| Physician Signature | | | Date/Time | |

| Patient Instructions | **Take All your medications as prescribed by your physician. Keep a list of your medications with you.<br>Contact your primary physician before taking any medications you have at home that are not on this list.<br>Contact your physician or pharmacist before taking any over-the-counter or herbal medications<br>Contact your physician or pharmacist about how to store your medications or how to dispose of and medications that are out of date or are no longer being taken.** |
|---|---|

***For Office Use Only:***

Height:_____ Pain Assessment Score:_____

Weight:_____ Fatigue Assessment Score:_____

Blood Pressure:_____ Comments:_____

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ED EVALUATION FORM

Patient Name: _____ MR#: _____*(office use only)*

Date of Birth: _____/_____/_____

| **PLEASE INDICATE (CIRCLE) THE APPROPRIATE NUMBERS BELOW** | | | | | | |
|---|---|---|---|---|---|---|
| 1) How do you rate your confidence that your could get and keep an erection? | | 1<br>VERY LOW | 2<br>LOW | 3<br>MODERATE | 4<br>HIGH | 5<br>VERY HIGH |
| 2) When you had erections with sexual stimulations, how often were your erections hard enough for penetration? | 0<br>NO SEXUAL ACTIVITY | 1<br>ALMOST NEVER | 2<br>A FEW TIMES | 3<br>SOMETIMES | 4<br>MOST TIMES | 5<br>ALMOST ALWAYS |
| 3) During sexual intercourse, how often were you able to maintain your erection? | 0<br>DID NOT ATTEMPT INTERCOURSE | 1<br>ALMOST NEVER | 2<br>A FEW TIMES | 3<br>SOMETIMES | 4<br>MOST TIMES | 5<br>ALMOST ALWAYS |
| 4) During sexual intercourse, how difficult is it to maintain your erection to completion of intercourse | 0<br>DID NOT ATTEMPT INTERCOURSE | 1<br>EXTREMELY DIFFICULT | 2<br>VERY DIFFICULT | 3<br>DIFFICULT | 4<br>SLIGHTLY DIFFICULT | 5<br>NOT DIFFICULT |
| 5) When you attempted sexual intercourse, how often was it satisfactory? | 0<br>DID NOT ATTEMPT INTERCOURSE | 1<br>ALMOST NEVER | 2<br>A FEW TIMES | 3<br>SOMETIMES | 4<br>MOST TIMES | 5<br>ALMOST ALWAYS |
| 6) How would you rate your ejaculate (fluid that comes out with an orgasm? | NORMAL | LESS THAN NORMAL | NONE | | | |

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# International Prostate Symptom Score (IPSS)

| Name: _____<br>Date of Birth: _____/_____/_____<br>MR#: _____*(office use only)*<br>Date Completed: _____ | Not at all | Less than 1 time in 5 | Less than half the time | About half the time | More than half the time | Almost always | **Your score** |
|---|---|---|---|---|---|---|---|
| Incomplete emptying<br>Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating? | 0 | 1 | 2 | 3 | 4 | 5 | |
| Frequency<br>Over the past month, how often have you had to urinate again less than two hours after you finished urinating? | 0 | 1 | 2 | 3 | 4 | 5 | |
| Intermittency<br>Over the past month, how often have you found you stopped and started again several times when you urinated? | 0 | 1 | 2 | 3 | 4 | 5 | |
| Urgency<br>Over the last month, how difficult have you found it to postpone urination? | 0 | 1 | 2 | 3 | 4 | 5 | |
| Weak stream<br>Over the past month, how often have you had a weak urinary stream? | 0 | 1 | 2 | 3 | 4 | 5 | |
| Straining<br>Over the past month, how often have you had to push or strain to begin urination? | 0 | 1 | 2 | 3 | 4 | 5 | |

| | None | 1 time | 2 times | 3 times | 4 times | 5 times or more | **Your score** |
|---|---|---|---|---|---|---|---|
| **Nocturia**<br>Over the past month, how many times did you most typically get up to urinate from the time you went to bed until the time you got up in the morning? | 0 | 1 | 2 | 3 | 4 | 5 | |

| Total IPSS score → | |
|---|---|

**Total score:** 0-7 Mildly symptomatic; 8-19 moderately symptomatic; 20-35 severely symptomatic.

| Quality of life due to urinary symptoms | Delighted | Pleased | Mostly satisfied | Mixed – about equally satisfied and dissatisfied | Mostly dissatisfied | Unhappy | Terrible |
|---|---|---|---|---|---|---|---|
| If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that? | 0 | 1 | 2 | 3 | 4 | 5 | 6 |

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# UPDATED PATIENT INFORMATION FORM

**Patient:** _____ **DOB:** _____/_____/_____

**Address:** _____

_____ **MR#:** _____*(office use only)*

_____

## Contact Information:

Email Address:_____ May we contact you via email? ☐yes /☐ No

Home Phone_____May we leave a message? ☐yes /☐ No

Mobile Phone_____May we leave a message?

☐ Voicemail ☐ Text Message ☐ None

Mobile Phone Provider_____

Work Phone _____ May we leave a message? ☐yes /☐ No

Emergency Contact (Name, Phone# & Relationship)_____

Advance Directive (Living Will) ☐ Yes (please provide a copy) ☐ No ☐ Would Like Information

Referring Urologist: <Referring Physicians-Name Only (Default)> Primary Cary Physician:_____

Race:_____ Ethnicity: _____ Preferred Language:_____

## MEDICAL HISTORY SINCE LAST VISIT:

PREVIOUS HOSPITALIZATION / SURGERIES / HIP REPLACEMENT / SERIOUS INJURIES:

_____

_____

Have you lived in or traveled to a country with widespread Ebola virus transmission or had contact with an individual with confirmed Ebola Virus Disease within the previous 21 days? No_____ Yes_____ Initials_____

Anesthesia History ☐ Uneventful ☐ Other

**Occupation:**_____

## PATIENT SOCIAL HISTORY

| Marital Status | Use of Alcohol | Use of Tobacco | Use of Illicit Drugs | Excessive Exposure at Home or Work to: |
|---|---|---|---|---|
| ☐Single | ☐Never | ☐Never | ☐Never | ☐Fumes_____ |
| ☐Married | ☐Rarely | ☐Previous but Quit | ☐Type & Frequency | ☐Solvent_____ |
| ☐Divorced | ☐Moderate | ☐Currently | _____ | ☐Chemicals_____ |
| ☐Widowed | ☐Daily | _____packs daily | _____ | ☐Other_____ |